SUMMARY OF BENEFITS

Connecticut General Life Insurance Co.

Maricopa County
CMG Network Copay Plan

Annual deductibles and maximums	In-network
Lifetime maximum	Unlimited per individual
Pre-Existing Condition Limitation (PCL)	Does Not Apply
Coinsurance	Plan pays 100% after the plan deductible is met
Contract year plan deductible • The plan deductible will apply to Inpatient Hospital Facility, Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities, Inpatient Hospice Facility, Outpatient Facility, Inpatient Hospice Bereavement Counseling services. The deductible must be satisfied before any benefits are payable for these services.	$350 Individual $700 Family
Contract year out-of-pocket maximum • Plan deductibles do not count towards your out-of-pocket maximum. • Includes advanced radiological imaging copays. Other copays do not accumulate. • Mental health and substance abuse services do not count towards your out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.	$1,000 Individual $2,000 Family

Benefits	In-network
Physician services	
Office visit copay	**Primary Care Physician** You pay $30 per visit **CCN Specialist** You pay $45 per visit **Non-CCN Specialist** You pay $70 per visit
Convenience Care Visit	You pay $20 per visit

Benefits	In-network
Allergy Treatment/Injections *Note: No charge after the per visit copay or the actual charge, whichever is less*	**Primary care physician** You pay $13 per visit **CCN Specialist** You pay $13 per visit **Non-CCN Specialist** You pay $28 per visit
Physician services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	**Inpatient and outpatient services** Plan pays 100% after the plan deductible is met
Surgery (in a physician's office)	**Primary Care Physician** You pay $30 per visit **CCN Specialist** You pay $45 per visit **Non-CCN Specialist** You pay $70 per visit
Preventive care	
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes lab and x-ray billed by the doctor's office	No charge
Mammogram, PSA, Pap Smear and Maternity Screening • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	No charge
Inpatient hospital facility services	
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.	$250 copay per admission, then Plan pays 100% after the plan deductible is met
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Included

Benefits	In-network
Outpatient services	
Outpatient surgery (facility charges) • Non-surgical treatment procedures are not subject to the facility copay.	$125 copay per visit, then Plan pays 100% after the plan deductible is met
Outpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge
Physical, occupational, cognitive and speech therapy • Limited to 60 days for all therapies combined per contract year • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	You pay $45 per visit
Outpatient cardiac rehabilitation • Limited to 36 days per contract year	You pay $45 per visit
Chiropractic • Limited to 24 days per contract year	You pay $30 per visit
Lab and X-ray	
Lab and X-ray • Physician's office	No charge
Lab and X-ray • Outpatient hospital facility • Independent x-ray and/or lab facility	No charge
Lab and X-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit. • Independent x-ray and/or lab facility in conjunction with a emergency room visit	No charge
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Physician's office visit	You pay a per scan copay of $100, then no charge
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Inpatient facility	Plan pays 100%
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Outpatient facility	You pay a per scan copay of $100, then Plan pays 100% after the plan deductible is met

Benefits	In-network
[Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Emergency room • Urgent care facility	You pay a per scan copay of $100, then no charge
Emergency and urgent care services	
Hospital emergency room • Including radiology, pathology and physician charges • Copay waived if admitted, then inpatient hospital charges would apply	You pay $200 per visit, then no charge
Ambulance Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	Plan pays 100%
Urgent care services • Copay waived if admitted, then inpatient hospital charges would apply.	You pay $75 per visit, then no charge
Other health care facilities	
Skilled nursing facility, rehabilitation hospital and other facilities • 90 days per contract year	Plan pays 100% after the plan deductible is met
Home health care • Limited to Unlimited days per contract year	No charge
Hospice	Plan pays 100% after the plan deductible is met
Other health care services	
Durable medical equipment • Unlimited per contract year maximum	You pay $75 copay per item
External prosthetic appliances (EPA) • Unlimited per contract year maximum	No charge

Benefits	In-network
Bariatric Surgery • Treatment of clinically severe obesity, as defined by the body mass index (BMI) • Waiting Period: One year from date of initial Employment (to be verified by Maricopa County)	You pay $500 Bariatric Copay, then:
Physician's Services/Office Visit	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay
Inpatient Hospital	$250 copay per admission, then Plan pays 100% after the plan deductible is met
Outpatient Facility Services	$125 copay per visit, then Plan pays 100% after the plan deductible is met
Inpatient Professional Services	No charge
Outpatient Professional Services	No charge
The following are excluded: *Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision*	
TMJ	Not Covered

Benefits	In-network
Maternity care services • Covers maternity for employee and all dependents.	
Initial Visit to Confirm Pregnancy	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay
All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)	No charge
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay
Delivery – Facility (Inpatient Hospital, Birthing Center)	$250 copay per admission, then Plan pays 100% after the plan deductible is met
Infertility	
Office visit for testing, treatment and artificial insemination	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay
Inpatient hospital facility	$250 copay per admission, then Plan pays 100% after the plan deductible is met
Outpatient hospital facility	$125 copay per visit, then Plan pays 100% after the plan deductible is met
Physician services **Surgical treatment limited to procedures to correct infertility, excluding In-vitro, GIFT, ZIFT, etc.**	You pay 50% of charges

Benefits	In-network
Family planning • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). • Includes contraceptive devices	
• **Office Visit**	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay
• **Inpatient hospital facility**	$250 copay per admission, then Plan pays 100% after the plan deductible is met
• **Outpatient facility**	$125 copay per visit, then Plan pays 100% after the plan deductible is met
• **Physician Services**	No charge
Hearing services	No charge after the $50 Specialist per office visit copay
Hearing Aids *Separate $2,000 Hearing Aid Maximum per ear per member every three years* *All providers covered*	No charge
Alternative Medical Services • Acupuncture/Acupressure • Biofeedback • Naturopathic • Other specific Approved Services Provided by a designated Alternative Medicine Provider • 20 visits per contract year • No prior authorization required	No charge after $30 per visit copay
Homeopathic/Herbal Medical Products • Herbal and homeopathic products which are approved by the HEALTHPLAN are covered at no charge when obtained at the Designated Alternative Medicine Center • Contract year Maximum of $60	No charge
Mental health and substance abuse services	
Mental Health and Substance Abuse	Carved out to Magellan
Prescription Drugs	
Pharmacy coverage	Carved out to Catalyst Rx

Benefits	In-network
Vision care	Carved out to EyeMed

Definitions

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Cost and reimbursement vary based upon place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Pre-existing condition limitation – Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Transition of Care – Provides in-network health coverage to new customers when the customer's doctor or facility is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor and/or remain in the same facility.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs , PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's not covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Treatment of sexual dysfunction
- Travel immunizations
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

Arizona, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.